

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT:  
MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

- i. The increase in the national hospital market basket price proxies (DRI) hospital cost index for the most recent twelve month period for which data are available; or
    - ii. The percentage increase in the statewide average hospital payment rate, as described in Section F.4.c. of this Chapter, over the previous year's statewide average hospital payment rate.
  - d. The adjustments calculated under Sections F.2.a. through F.2.c. of this Chapter shall be paid on a per diem basis and shall be applied to each covered day of care provided.
3. Medicaid High Volume Adjustment Limitations.
- Hospitals that qualify for MHVA adjustments under Sections F.2.a. through F.2.c. above shall not be eligible for such MHVA adjustments if they are no longer recognized or designated by the Department as a DSH hospital, as required by Section F.1.a. In this instance, the annual adjustment described in Sections F.2.a. through F.2.c. shall be pro-rated, as applicable, based upon the date that the hospital was deemed ineligible for DSH payment adjustments, under Section C. of this Chapter, by the Department.
4. Medicaid High Volume Adjustment Definitions. The definitions of terms used with reference to calculation of the MHVA adjustments required by Section F. are as follows:

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- ==07/95           a. "MHVA base fiscal year" means, for example, the hospital's fiscal year ending in 1991 for the October 1, 1993, MHVA determination year, the hospital's fiscal year ending in 1992 for the October 1, 1994, MHVA determination year, etc.
- ==07/95           b. "MHVA rate period" means, beginning October 1, 1993, the 12 month period beginning on October 1 of the year and ending September 30 of the following year.
- ==07/95           c. "Statewide Average Hospital Payment Rate" means the hospital's alternative reimbursement rate, as defined in Section B. of Chapter VIII.

==07/95 G. Inpatient Payment Adjustments Based Upon Reviews

Appeals based upon a hospital's ineligibility for the inpatient payment adjustments described in Sections E. and F. of this Chapter, or their payment adjustment amounts, in accordance with Chapter IX., which result in a change in a hospital's eligibility for inpatient payment adjustments or a change in a hospital's payment adjustment amounts, shall not affect the inpatient payment adjustments of any other hospital or the payment adjustment amount of any other hospital that has received notification from the Department of their eligibility for inpatient payment adjustments based upon the requirements of Section E. and F. of this Chapter.

==07/95 H. Reductions to Total Payments

- ==07/95           1. Copayments. Copayments are assessed under all medical programs administered by the Department except the Children and Family Assistance Program, formerly known as the General Assistance medical program, and shall be assessed in accordance with Chapter VII.
- ==07/95           2. Third Party Payments. Hospitals shall determine that services are not covered, in whole or in part, under any program or under any other private group indemnification or insurance program, health maintenance organization, workers compensation or the tort liability of any third party. To the extent that such coverage is available, the Department's payment obligation shall be reduced.

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## 09/91 A. Total Medicaid Payment

10/93 Under the DRG PPS, the total payment for inpatient hospital services furnished to a Medicaid client by a hospital will equal the sum of the payments listed in Sections B. through C. of this Chapter. In addition to the payments listed in Sections B. through C. of this Chapter, hospitals shall also receive disproportionate share adjustments, if applicable, and various specific inpatient payment adjustments in accordance with Chapter VI, if applicable.

## 10/93 B. Determination of Payment

10/93 A hospital will be paid the following amounts:

1. The appropriate DRG PPS rate for each discharge as determined in accordance with Chapter IV.
2. The appropriate outlier payment amounts determined under Chapter V.

10/93 3. Capital related costs as determined under Section C. of this Chapter.

## ==07/95 C. Payments for Capital Costs.

==07/95 For the rate periods described in Section B.2. of Chapter XVI., these costs shall be paid on a per case basis. Payments for these costs shall be calculated as follows:

## 10/93 1. Capital Related Costs

==07/95 a. For the rate period described in Section B.2.a. of Chapter XVI.:

==07/95 i. The capital related cost per diem shall be calculated by taking the hospital's total capital related costs as reported on the hospital's latest audited Medicare cost report on file with the Department for the base period as defined in Section B.1. of Chapter XVI., divided by the hospital's total inpatient days, trended forward to the mid-point of the rate period using the national total hospital market basket price proxies, (DRI).

10/93 ii. These two trended capital-related cost per diems are then added together and divided by two to calculate the hospital's adjusted capital-related cost per diem.

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- 10/93           iii. The adjusted capital-related cost per diem amount as calculated in Section C.1.a.ii. above shall be rank ordered for all hospitals and capped at the 80th percentile.
- 10/93           iv. Each hospital shall receive a per case add-on for capital-related costs which shall be equal to the amount calculated in Section C.1.a.ii. or C.1.a.iii. above, whichever is less, multiplied by the hospital's average length of stay for services reimbursed under the DRG PPS.
- ==07/95       b. For the rate periods described in Section B.2.b. of Chapter XVI.:
- 10/93           i. Capital related cost per diem shall be calculated in accordance with Sections C.1.a.i. through C.1.a.iii. above.
- ==07/95       ii. Each hospital shall receive a per diem add-on for capital related costs which shall be equal to the amount calculated in Section C.1.a.i. or Section C.1.a.iii. above, whichever is less, multiplied by the hospital's average length of stay for services reimbursed under the DRG PPS.
- ==07/95       2. A hospital wishing to appeal the calculation of its rates must notify the Department within 30 days after receipt of the rate change notification, in accordance with the provisions of Chapter IX.

09/91 D. Method of Payment

1. General Rule

Unless the provisions of Section D.2. of this Chapter apply, hospitals are paid for each discharge based on the submission of a discharge bill. Payments for inpatient hospital services furnished by an excluded distinct part psychiatric or a rehabilitation unit of a hospital are made under Alternate Reimbursement Systems set forth in Chapter VIII.

2. Special Interim Payment for Unusually Long Lengths of Stay

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a. First Interim Payment

A hospital may request an interim payment after a Medicaid client has been in the hospital at least 60 days. Payment for the interim bill is determined as if the bill were a final discharge bill and includes any outlier payment determined as of the last day for which services have been billed.

b. Additional Interim Payments

A hospital may request additional interim payments at intervals of at least 60 days after the date of the first interim bill submitted under Section D.2.a. of this Chapter. Payment for these additional interim bills, as well as the final bill, is determined as if the bill were the final bill with appropriate adjustments made to the payment amount to reflect any previous interim payment made under the provisions of Section D.2. of this Chapter.

3. Outlier Payments

Except as provided in Section D.2. of this Chapter, payment for outlier cases (described in Chapter V.) are not made on an interim basis. The outlier payments are made based on submitted bills and represent final payment.

09/91 E. Reductions to Total Payments

1. Copayments

10/92

a. Copayments will be assessed on inpatient hospital services in the following amounts:

- i. Inpatient hospital services in hospitals with an alternate cost per diem rate (see Section B.1. of Chapter VIII.) of \$325 or more.....\$3 per day.
- ii. Inpatient hospital services in hospitals with an alternate cost per diem rate (see Section B.1. of Chapter VIII.) of more than \$275 but less than \$325.....\$2 per day.
- iii. Inpatient hospital services in hospitals with an alternate cost per diem rate (see Section B.1. of Chapter VIII.) of \$275 or less.....No Copayment.

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- 10/92
- b. Copayments will be assessed under all medical programs administered by the Department except the Children and Family Assistance Program (formerly known as the General Assistance program. Copayments will not be assessed against individuals under the age of 18, pregnant women (including post-partum women who have given birth within the last six weeks), or group care recipients. Copayments will be deducted automatically by the Department upon payment for services provided.
  - c. No provider may deny care or services on account of an individual's inability to pay a copayment; this requirement, however, shall not extinguish the liability for payment of the copayment by the individual to whom the care or services were furnished.

2. Third Party Payments

Hospitals shall determine that services rendered are not covered, in whole or in part, under any other state or federal medical care program or under any other private group indemnification or insurance program, health maintenance organization, preferred provider organization, workers compensation or the tort liability of any third party. To the extent that such coverage is available, the Department's payment obligation shall be reduced.

- 09/91
- F. Effect of Change of Ownership on Payments under the DRG Prospective Payment System. When a hospital's ownership changes, the following rules apply:
- 1. The owner on the date of discharge is entitled to submit a bill for all inpatient hospital services furnished to a Medicaid client regardless of when the client's coverage began or ended during a stay, or of how long the stay lasted.
  - 2. Each bill submitted must include all information necessary for the Department to compute the payment amount, whether or not some of that information is attributable to a period during which a different party legally owned the hospital.
- ==07/97
- G. All payments calculated under Sections ~~C-1, B and C~~ above, in effect on January 18, 1994, shall remain in effect ~~until June 30, 1997 hereafter.~~

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## 09/91 A. Determination of Alternate Payment Rates to Certain Exempt Hospitals

1. The exempt hospitals, defined in Sections C.1., C.2., C.4., and C.7. of Chapter II., shall be reimbursed for inpatient hospital care provided to recipients by summing the following reimbursement calculations:

- a. allowable operating cost per diem;

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- b. capital costs reimbursed on a per diem basis;

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- c. applicable disproportionate share adjustments as described in Section C. of Chapter VI. and outlier adjustments as described in Section F. of this Chapter; and

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==07/95            d. applicable trauma center adjustments and Medicaid high volume adjustments, as described in Sections E. and F. of Chapter VI.; and Critical Hospital Adjustment Payments as described in Chapter XV.

2. Calculation and definitions of inpatient per diem rates.

10/92            a. Calculation for the first rate period

i. allowable operating cost per diem

==07/95            A) The allowable operating cost per diem for a hospital, described in Section A.1. of this Chapter, and for hospitals or hospital units, described in Sections B.1. and B.2. of this Chapter, shall be calculated by taking the hospital's Medicaid inpatient operating costs for the base period, as defined in Section B.1. of Chapter XVI., divided by the hospital's Medicaid inpatient days.

10/92            B) Operating cost base per diem rates for hospital inpatient care provided to Medicaid recipients beginning September 1, 1991, shall be calculated by:

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- 1) Calculating each individual hospital's cost per diem less capital and direct medical education costs for each of the two most recent years for which an audited Medicaid cost report exists, as described in Section A.2.a.i.A) above.
- 10/92 2) Each of the two cost per diems shall be trended forward to the midpoint of the rate period using the national total hospital market basket price proxies, (DRI).
- ==07/95 3) These two trended operating cost per diems are then added together and divided by two to calculate the hospital's average operating cost per diem.
- ==07/95 4) The average operating cost per diem calculated in A.2.a.i.B)3) of this Chapter is then divided by the indirect medical education (IME) factor, determined by the Health Care Financing Administration (HCFA), in effect 90 days prior to the admission in order to calculate the hospital's final operating cost per diem for the base period. For other hospitals for which an indirect medical education factor is not available, the Department shall calculate an indirect medical education factor using the hospital's most recently available cost report and the Medicare formula in effect 90 days prior to the date of admission.

ii. Capital related costs

- ==07/95 A) The capital related cost per diem for a hospital, described in Section A.1. of this Chapter, and for hospitals or hospital units, described in Sections B.1. and B.2. of this Chapter, shall be calculated by taking the hospital's total capital-related costs for the base period, as defined in Section B.1. of Chapter XVI., divided by the hospital's total inpatient days, trended forward to the midpoint of the rate period using the national total hospital market basket price proxies, (DRI).
- B) These two trended capital-related cost per diems are then added together and divided by two to calculate the hospital's adjusted capital-related cost per diem.

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- C) The adjusted capital-related cost per diem as calculated in A.2.a.ii.B) above shall be rank ordered for all hospitals and capped at the 80th percentile.
- D) Each hospital shall receive a per diem add-on for capital-related costs which shall be equal to the amount calculated in Sections A.2.a.ii.B) or A.2.a.ii.C) above, whichever is less.

## iii. Direct medical education costs

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- A) The direct medical education costs for a hospital described in Section A.1. above, and for hospitals or hospital units described in Sections B.1. and B.2. below, shall be calculated by taking total inpatient direct medical education costs for the base period, as defined in Section B.1. of Chapter XVI., divided by the hospital's total inpatient days, trended forward to the midpoint of the rate period using the national total hospital market basket price proxies, (DRI).
- B) These two trended direct medical education cost per diems are then added together and divided by two to calculate the hospital's adjusted direct medical education cost per diem.

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